Dental History

Please answer the following questions regarding your dental history. All of the answers to these questions will be evaluated in addition to the records that are taken during the clinical examination to determine causes and solutions to any dental problems that you may be experiencing. Thank you in advance for taking the time to fill out this detailed questionnaire. Circle answer in parenthesis.

1. General Dental History

How often do you brush? _____ Type of Toothpaste used? _____

Manual toothbrush or Electric? _____ How often do you floss? _____

2. Habits

Are you aware of grinding or clenching your teeth? (Yes/ No) _____

Do you bite your cheeks? Yes/ No Is this a Habit? (Yes/ No)

Do you have sinus or nasal issues that may cause you to breathe more from your mouth than your nose? (Yes/No), explain._____

Do you snore? (Yes/ No/ Not Sure)

Do you smoke cigarettes, cigars, pipes or vape? _____ Smokeless tobacco? (Yes/No)

Do you bite your nails? (Yes/No) Have you ever sucked your thumb? (Yes/No)

Do you use toothpicks or interproximal brushes? (Yes/No)?

Do you chew gum regularly? (Yes/ No) If so, do you have any issues with chewing for a long time?_____

How often do you eat candy, and what type? _____

How many soft drinks do you drink daily? _____ Weekly? _____

Do you drink alcoholic beverages? (Yes/No) If so, how many drinks _____ per (day, week, month)?

Do you have any cosmetic or dental concerns that you want to address? Are you interested in whitening or lightening your teeth? Any painful conditions that you need addressed? _____
_____

Patient Name: _____ Date: _____